BEFORE THE BOARD OF MEDICAL EXAMINERS

IN THE STATE OF ARIZONA

In the Matter of

DEBORAH D. MORONEY, M.D.

Holder of License No. **20826** For the Practice of Medicine In the State of Arizona.

Board Case No. MD-99-0852

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

(Letter of Reprimand)

This matter was considered by the Arizona Board of Medical Examiners ("Board") at its public meeting on August 15, 2001. Deborah D. Moroney, M.D., ("Respondent") appeared before the Board without legal counsel, for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(G). After due consideration of the facts and law applicable to this matter, the Board voted to issue the following findings of fact, conclusions of law and order.

FINDINGS OF FACT

- 1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.
- 2. Respondent is the holder of License No. 20826 for the practice of medicine in the State of Arizona.
- 3. The Board initiated case number MD-99-0852 upon receiving a complaint regarding Respondent's treatment and care of a patient.
- 4. On August 27, 1999, patient P.P., a sixty-eight year old female, who complained of abdominal pains for the past ten days, saw her primary care physician. The primary care physician ordered a CAT Scan, admitted the patient to Yavapai Regional Medical Center, and turned over the care of patient P.P. to Respondent, the on-

call doctor for the group. On that evening Respondent was notified of an abnormal lab result. She diagnosed a urinary tract infection, ordered antibiotics and repeat labs.

- 5. On August 28, 1999, Respondent saw patient P.P., who was awake, alert and able to interact, but her abdomen was distended. Respondent discussed patient P.P.'s history of alcohol use. Respondent noted possible alcoholic liver cirrhosis with ascites. The CAT Scan results were not available.
- 6. On August 29, 1999, a dictated CAT Scan report was retrieved by Respondent. According to Respondent's progress notes, the dictated CAT Scan report referred to "a shrunken liver consistent with cirrhosis or infiltrative process. Marked ascites with free fluid versus gas in the bowel loops." Respondent requested a gastroenterological consultation, but suggested it could wait until the next day. However, the dictated CAT Scan report suggested a timely surgical consult should have been ordered.
- 7. On the evening of August 29, 1999, patient P.P. experienced bladder fullness but was not voiding and a catheter was placed. Patient P.P. became agitated and the nurses contacted Respondent for a medication order. Respondent noted that patient P.P. was suffering from alcohol withdrawal symptoms and ordered Librium.
- 8. On August 30, 1999, patient P.P.'s primary care physician re-assumed care of the patient and found that her condition had deteriorated. Her abdomen was further distended and was hard with rebound tenderness and there were no bowel sounds.
- 9. The primary care physician diagnosed a ruptured viscus. He requested a surgical consult and surgery revealed 3-4 liters of free fluid and two perforated-abscessed diverticuli. Patient P.P. died on September 11, 1999. According to the autopsy report, patient P.P. died after a reported perforated colonic diverticulum and the

delay in surgery to perform a diverting colostomy procedure further compromised her ability to survive the peritonitis that followed the colonic perforation.

10. Respondent fell below the standard of care in failing to timely request an indicated surgical consultation, thus contributing to the death of P.P.

CONCLUSIONS OF LAW

- 1. The Board of Medical Examiners of the State of Arizona possesses jurisdiction over the subject matter hereof and over Respondent.
- 2. The conduct and circumstances described above in paragraphs 4 through 10 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(q)("[a]ny conduct or practice which is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that Respondent is issued a Letter of Reprimand for failing to timely request an indicated surgical consultation.

RIGHT TO PETITION FOR REVIEW

Respondent is hereby notified that she has the right to petition for a rehearing. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing must be filed with the Board's Executive Director within thirty (30) days after service of this Order and pursuant to A.A.C. R4-16-102, it must set forth legally sufficient reasons for granting a rehearing. Service of this order is effective five (5) days after date of mailing. If a motion for rehearing is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing is required to preserve any rights of appeal to the Superior Court.

1	DATED this _2/10 day of, 2001.	
2	EXAMINERS	BOARD OF MEDICAL EXAMINERS
3 4		OF THE STATE OF ARIZONA
5	8 1913 A	By Claudia Lout
6	OS TOWNING THE TOWN T	CLAUDIA FOUTZ Executive Director
7		TOM ADAMS Deputy Director
8	ORIGINAL of the foregoing filed this 29 day of <u>August</u> , 2001 with:	
10	The Arizona Board of Medical Examiners 9545 East Doubletree Ranch Road Scottsdale, Arizona 85258	
11	Scottsdale, Alizona 03230	
12	mailed by U.S. Certified Mail this day of August 2001, to:	
14 15	Deborah D. Moroney, M.D. Rt. 30 Box 1060 Prescott, Arizona 86305	
16 17	Copy of the foregoing hand-delivered this 29 day of August , 2001, to each of	
	the following:	
18	Christine Cassetta, Assistant Attorney General	
19	Sandra Waitt, Management Analysts	
20	Lisa Maxie-Mullins, Legal Coordinator (Investigation File) Arizona Board of Medical Examiners	
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